White Bird Medical Clinic

1400 Mill Street Eugene, Oregon 97401 541.484.4800

NAME: _____ **Date of Birth:** _____

CONSENT TO TREATMENT

By signing below, I, (or my authorized representative on my behalf) authorize White Bird Medical Clinic and their staff to conduct any diagnostic examinations, tests, and procedures and to provide any medications, treatment, or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

RIGHT TO REFUSE TREATMENT

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

_____

SIGNATURE TODAY'S DATE

_____

SIGNATURE (PARENT OR GUARDIAN) TODAY'S DATE

ACKNOWLEDGEMENT AND CONSENT

I understand and agree that White Bird Medical Clinic may use and disclose my health information in the manner described in White Bird Medical Clinic's *Notice of Privacy Practices*. By signing below, I agree that I have reviewed and understand the information included in the *Notice of Privacy Practices* and have been given the option to receive a printed copy of that notice.

_____

SIGNATURE TODAY'S DATE

_____

SIGNATURE (PARENT OR GUARDIAN) TODAY'S DATE

Please complete the backside

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PERMISSION TO BILL INSURANCE

In order for White Bird Medical Clinic to process your insurance claims, we will need your signature to release payment. I authorize the release of any information relating to any claim for services rendered to me or my dependents. I assign and request your company to pay directly to White Bird Medical Clinic insurance benefits otherwise payable to me or my dependents. I understand I am financially responsible to White Bird Medical Clinic for charges not covered by this assignment.

_____

SIGNATURE TODAY'S DATE

_____

SIGNATURE (PARENT OR GUARDIAN) TODAY'S DATE

PERMISSION TO COORDINATE CARE

I understand and agree that White Bird Medical Clinic may use and disclose my health information to other White Bird Clinic programs as well as to other service organizations for the purpose of coordinating care with those entities. If the information to be disclosed contains any of the information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____*HIV/AIDS information; _____*Mental Health information; _____*Genetic Testing information; _____*Drug/Alcohol information.

**Must be initialed to be included in other documents. Records will not be released without your initials specifying you have granted this specific release authority.*

_____

SIGNATURE TODAY'S DATE

_____

SIGNATURE (PARENT OR GUARDIAN) TODAY'S DATE

PATIENT RIGHTS AND RESPONSIBILITIES

I have read and understand my rights and responsibilities as a patient of this practice (White Bird Medical Clinic - *Patient Rights and Responsibilities)* I understand that it is imperative that I meet these responsibilities in order to remain a patient at this practice.

☐ Yes! I have read and understand my rights and responsibilities as a patient of this practice.

_____

SIGNATURE TODAY'S DATE

_____

SIGNATURE (PARENT OR GUARDIAN) TODAY'S DATE